

**OKLAHOMA STATE DEPARTMENT OF HEALTH**  
**SPECIAL HEALTH SERVICES-0511**  
 Health Resources Development Service  
 P.O. Box 268823  
 Oklahoma City, OK 73126-8823  
 Telephone (405) 271-6868 Fax (405) 271-7360

**STAFFING PROJECTION AND  
 PROFESSIONAL CERTIFICATION FOR  
 A NURSING OR LONG-TERM CARE FACILITY**

1. Name of Facility: \_\_\_\_\_
2. Projected Staffing Pattern - Show number of full-time employees per shift. Blank columns may be used for staff not already designated.

Shift Times	RN	LPN	Nurse Aide/CMA	House Keeping	Laundry	Activity	Social Service	Food Service	Mainten-ance		

3. I, \_\_\_\_\_, a Registered Nurse/Licensed Practical Nurse (circle one), in the State of Oklahoma am employed to supervise the nursing service for this facility as defined by the Act and Standards.

\_\_\_\_\_  
 Signature License Number Date

4. I, \_\_\_\_\_, a Physician duly licensed to practice in the State of Oklahoma agree to be on call for medical care emergencies and to act in an advisory capacity as defined by the Act and Standards for this facility.

\_\_\_\_\_  
 Signature License Number Date

\_\_\_\_\_  
 Street Address City State Zip (Area Code) Telephone Number

5. I, \_\_\_\_\_, a Pharmacist duly licensed to practice in the State of Oklahoma and practicing at a licensed pharmacy, agree to provide consulting and emergency pharmacy services for this facility as in the Act and the Standards.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Street Address                      City                      State    Zip    (Area Code) Telephone Number

6. I, \_\_\_\_\_, a Registered and licensed Dietician or qualified nutritionist. Agree to consult, supervise and advise regarding nutritional needs of residents, as defined by the Act and Standards for the facility.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Street Address                      City                      State    Zip    (Area Code) Telephone Number

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**I certify that the foregoing is true and complete to the best of my knowledge and belief.**

\_\_\_\_\_  
Typed or Printed Name of Person Signing for Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Name of Corporation, Partnership or Association

\_\_\_\_\_  
Official Title or Position

State of \_\_\_\_\_

County of \_\_\_\_\_

Signed and sworn to (or affirmed) before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Name(s) of person(s) making statement.

Seal or Stamp:

\_\_\_\_\_  
Signature of Notary Public

My Commission Expires: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

My Commission Number is: \_\_\_\_\_